# CHAPTER VI

# UTILIZATION REVIEW AND CONTROL

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## INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

## COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

**FRAUDULENT CLAIMS**

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

## REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours

referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

**GENERAL REQUIREMENTS FOR MENTAL RETARDATION COMMUNITY SERVICES UTILIZATION REVIEW**

DMAS conducts utilization review to assure that the services provided are appropriate and comply with the policies and procedures for the provision of Mental Retardation Waiver (MR Waiver) services. For the general requirements, DMAS uses the following procedures:

1. DMAS will conduct an on-site review of service delivery in each Community Services Board (CSB) or Behavioral Health Authority (BHA) catchment area at least annually.

2. Utilization Review (UR) is comprised of desk audits, on-site record review, and may include observation of service delivery, as well as face-to-face or telephone interviews with the individual or family or significant other(s), or both. The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, numbers of private providers, etc.

3. Billing records are matched to service delivery documentation. Any infractions will be cited in the Utilization Review written report and may result in billing overpayments, voids to continued billing, or a request for a Plan of Correction.

4. Utilization Reviews will be unannounced.

5. Providers may be asked to bring program and billing records to a central location.

6. Upon completion of on-site activities for a routine UR, DMAS staff will be available to meet with designated staff to conduct an exit conference. Representatives of private providers affiliated with the CSB/BHA may be included. The purpose of the Exit Conference is for DMAS to provide a general overview of the UR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices.

7. Following the review, a written report of the findings is sent to the CSB/BHA and copied to providers who were included in the review.

8. If a billing adjustment is needed, it will be outlined in the report to the CSB/BHA, as will the timeline for submitting the adjustment.

9. If a Plan of Correction is requested, the Provider will have 30 days (unless otherwise indicated) from receipt of the UR report to submit the Plan for approval.

10. Findings identified in the written report are subject to a request from the CSB/BHA or provider for reconsideration. The procedures for submitting a request are specified in the cover letter that accompanies the written UR report and must be submitted within 30 days of receipt of the letter.

11. If there are findings that are related to licensing procedures, a letter stating these findings will be submitted to the appropriate licensing or approving agency.

12. DMAS will follow up on any Plans of Correction that are completed to ensure that corrective procedures within the Plan are implemented by the provider.

**REVIEW OF TARGETED MENTAL RETARDATION CASE MANAGEMENT AND MENTAL RETARDATION COMMUNITY WAIVER SERVICES**

In addition to the general UR requirements, DMAS also reviews for specific requirements for the provision of Mental Retardation Targeted Case Management (MR Targeted Case Management) and Mental Retardation Community Waiver Services. These requirements are: eligibility for services; that the services are based on comprehensive and ongoing assessment and planning; that services are delivered, reviewed, and modified; that the provider is qualified; and that the services are consistent with billing limitations. Specific requirements for each area follow.

<u>Eligibility for Services</u>

A. The individual meets the following diagnostic criteria:

1. There must be documentation in the case management record that an individual six years of age or older receiving *Targeted MR Case Management* services has mental retardation as defined by the American Association of Mental Retardation (AAMR): "being

substantially limited in present functioning that is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, manifested before age 18." A psychological evaluation must be completed by a licensed professional, contain a diagnosis of mental retardation, reflect the individual's current status, and have been completed prior to service initiation. In order to confirm a diagnosis of mental retardation, a psychological evaluation addresses intellectual functioning, adaptive behavior, and age of onset.

2. There must be documentation in the case management record that a child under six years of age receiving MR Targeted Case Management services has mental retardation as defined by AAMR. This documentation does not have to specifically state a diagnosis of mental retardation. However, the instrument should be a standardized developmental evaluation and must convey evidence of cognitive and adaptive developmental delay or presence of a syndrome typically associated with mental retardation. The evaluation must reflect the individual's current status and have been completed prior to service initiation."

3. There must be documentation in the case management record that an individual six years of age or older receiving MR Community Waiver services has mental retardation as defined by AAMR: "being substantially limited in present functioning that is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, manifested before age 18."

4. There must be documentation in the case management record that a child under six years of age receiving MR Waiver services has mental retardation or is at developmental risk (based on a psychological evaluation or standardized developmental evaluation). Developmental risk is defined in the state regulations as "the presence before, during or after birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through available diagnostic and evaluative criteria." Documentation of developmental risk must reflect the child's current status and have been completed prior to service initiation.

B. The individual meets functional eligibility. For individuals receiving MR Waiver, the ICF-MR Level of Functioning Survey (LOF) must be in the case management record, have been completed no more than six months prior to the start of Waiver services, and document that the individual meets the dependency level in two or more of the categories. This must be reviewed and completed annually and reflect the current status of the individual.

C. There is basis for initiating 90-Day MR Targeted Case Management.

1. Referral information for an individual to receive Targeted 90-Day Case Management services must be clearly documented and provide a basis for this service. This includes evidence in the case management record that a) the individual had not previously received formal case management services; b) did not have diagnostic information necessary to determine eligibility; (c) there was reason to suspect the presence of mental retardation; and d) an indication of a need for ongoing active case management services.

2. Documentation must indicate that the 90-day ISP began no earlier than the date of the initial face-to-face contact with the individual and ended when the assessment information (diagnosis and need for active case management) was completed, but no later than 90 days from the start date. Billing can occur for a maximum of three months. If prior to the end of the 90 days, an individual was determined ineligible, appropriate notification of the right to appeal must be sent to the individual.

D. There is basis for initiating MR Targeted Case Management services.

1. There must be documentation of diagnostic eligibility in the record of an individual receiving MR Targeted Case Management services.

2. There must be documentation that the individual requires and receives active case management services.

3. MR Targeted Case Management services must not duplicate any other Medicaid service provided under the Virginia *State Plan for Medical Assistance* or under any Waiver other than the MR Waiver.

E. There is basis for initiating MR Waiver services.

1. The case management record for an individual receiving MR Waiver services must indicate that the individual meets both diagnostic and functional eligibility as described above.

2. Documentation must be evident that the individual is receiving MR Targeted Case Management at the time MR Waiver services are initiated and during any month in which MR Waiver services are provided. As with any MR Targeted Case Management individual, a case management Individual Service Plan (ISP) must be available in the record.

3. Documentation must indicate that the individual meets the urgent criteria (outlined in Chapter IV, "Urgent Criteria" section) at the time of enrollment.

F. The individual continues to meet eligibility for services.

1. It should be clearly documented in the case management record that the individual's eligibility and need for continuation of any MR Waiver service is reviewed at least annually.

2. To confirm continued diagnostic eligibility for MR Waiver services, the case management record must contain a psychological evaluation (or standardized developmental assessment for children under six years of age) that reflects current psychological status. There should be documentation that an updated psychological evaluation is completed whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

3. The case management record must contain an ICF-MR Level of Functioning (LOF) Survey that was administered on an annual basis by the case manager. The individual must meet the indicated dependency level in 2 or more of the categories on the LOF.

<u>MR Waiver Services are Based on Comprehensive and Ongoing Assessment and Planning</u>

A. A Consumer Service Plan is completed and reviewed.

1. The case management record must include a Consumer Service Plan (CSP) that organizes the services and supports that are

provided to the individual. The four essential components to a CSP include a) a Social Assessment, b) primary goals, needs, and outcomes desired by the individual, c) an Individual Service Plan (ISP) for each MR Waiver service (including Targeted MR Case Management), and d) a signature page or documentation of agreement by those participating in the development and implementation of the CSP.

2. There must be evidence that the CSP is reviewed by the case manager and updated annually and whenever changes or service modifications occur.

B. There is comprehensive and current assessment information.

1. There must be a Social Assessment in the case management record, completed by the case manager, no earlier than one year prior to start date of services and updated annually. This assessment must include a review of the current situation and the individual's strengths and desires within the following areas:

    - Physical/Mental Health, Personal Safety and Behavior Issues;
    - Financial, Insurance, Transportation, Other Resources;
    - Home and Daily Living;
    - Education and Vocation;
    - Leisure and Recreation;
    - Relationships and Social Supports;
    - Legal Issues and Guardianship; and
    - Individual Empowerment, Advocacy and Volunteerism.

2. There should be medical information in the case management record for any individual receiving MR Waiver services. Individuals receiving MR Waiver services must have a medical examination completed no earlier than 12 months prior to the start of Waiver services. Documentation should indicate that additional evaluations occur whenever indicated. Medical examinations of children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by the Department of Medical Assistance Services (DMAS). (See the "Exhibits" section at the end of Chapter IV.)

3. The case management record for an individual receiving MR Waiver services should contain the DMHMRSAS approved assessment instrument, completed no more than 12 months prior to the start date of Waiver Services and updated annually.

4. The functional assessment information used to develop the ISP must be available in the service provider record and reflect an individualized approach to gathering additional information about the individual's personal preferences, interests, strengths, and attributes.

C. The individual and others, as appropriate, are involved in the planning process.

1. Documentation must indicate that the individual (or legal guardian, when appropriate) provided consent to exchange information with other agencies. The case management record of an individual must contain a signed copy of the DMAS-20 form entitled "Consent to Exchange Information," completed prior to the initiation of MR Waiver services (see the "Exhibits" section at the end of Chapter IV).

2. Documentation must indicate that the individual (or legal guardian, when appropriate) was given the choice between institutional care and MR Waiver services. The case management record must contain a copy of the form entitled "Documentation of Recipient Choice between Institutional Care or Home and Community Based Services." This is required at the initiation of any Waiver services and should be maintained in the individual's case management record (see the "Exhibits" section at the end of Chapter IV).

3. Documentation must be in the case management record that the individual has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the MR Waiver (this can be done on the recipient choice form).

4. Documentation must indicate that the individual (or legal guardian) was informed of all MR Waiver providers in the community and had the option of choosing from among qualified providers. It must be clear that the choice of providers was offered no more than six months prior to the initiation of any Waiver services, whenever new services were added, when changes occur in providers, or when requests are made by the individual. The choice must be documented in writing, prior to

the start of services, by having the individual (or parent or guardian when appropriate) sign a list of available providers and designate the selected provider. While it is the responsibility of service providers to indicate their availability to each CSB/BHA where they may potentially provide services, it is suggested that the CSB/BHA review the updated roster of approved providers distributed by DMHMRSAS.

5. Documentation must indicate that the individual (or legal guardian or family) was involved in the development of the CSP. The team should meet within 30 calendar days of DMHMRSAS verification of an available slot to discuss the individual's needs, existing supports, Agency-Directed and Consumer-Directed service options for developing the CSP. At a minimum, the individual's (and family's) input and satisfaction with the plan should be documented by signature(s) on the CSP in addition to the case manager's signature.

6. Documentation must indicate that the individual (or legal guardian) was informed of any changes in services, provided the opportunity for input, and agreed to the changes before they were implemented. Documentation of this involvement (either in the CSP itself or in the case notes) should accompany any changes to the CSP.

7. For any termination or decrease of Targeted MR Case Management or MR Waiver service, the case management record must contain written notification to the individual of the pending action and the right to appeal. See Chapter IV, "Recipient's Right to Appeal and Fair Hearing" for specific requirements.

D. The case manager receives and reviews each Individual Service Plan (ISP).

1. Each ISP must be completed prior to the initiation of services and must designate supports based on current information, reflective of the individual's desires, input, and other assessment information and agreed to by the team.

2. Each ISP must clearly describe the activities of the individual and staff, reflecting training and supports that are specific and include measurable objectives, as appropriate for the individual and congruent with the type and amount of service units on the Individual Service Authorization Request (ISAR). The ISP must

justify service components such as day support intensity levels, residential specialized supervision, periodic supports, etc.

3. Each ISP must include activities and strategies that are meaningful and address the individual's primary goals. Each ISP must satisfy the specific Medicaid criteria and service limitations for each individual service as described in Chapter IV.

4. The schedule of services must be consistent with the service units on the ISAR.

5. When a 60-day assessment period is utilized for Residential Support, Personal Assistance (Agency Directed), Day Support, Prevocational, or Supported Employment services, there must be evidence that the individual is new to the program and a preliminary ISP and schedule of services are included in the record. Documentation must confirm attendance and provide specific information as described in the ISP objectives. There must be an annual ISP, based upon the assessment information, developed prior to the last day of the assessment period.

E. Documentation of all planned services. The Plan of Care Summary is completed annually by the case manager and updated as needed. It should list all current MR Waiver and non-waiver services.

<u>Services Are Delivered, Reviewed, and Modified</u>

A. Services occur as planned or are adjusted to accommodate the individual's needs and requests.

1. There must be ongoing documentation in the record of each service provider regarding the services to the individual and available for review by the case manager, DMHMRSAS, DMAS, the individual or family or both. Documentation can include case notes, various modes of measurable data collection, attendance records, notes regarding significant incidents, monthly summaries, and progress notes.

2. The record must document a minimum of one face-to-face contact with the individual within each 90-day period. There must be evidence that the case manager assessed the individual's satisfaction with services (through observation and interviews with the individual and significant others), determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as appropriate. Missed face-to-face contacts with no documented reason, particularly

patterns of missed contacts, may result in the entire quarter being disallowed for reimbursement.

3. Each service provider's records (including case management) must contain documentation that corresponds to the ISP objectives and indicates that services have been provided according to the plan. While this data may take many forms, it should be meaningful for the individual and his or her goals being addressed.

B. Services are reviewed at least quarterly.

1. There must be documentation that the case manager reviewed on a quarterly basis all services provided (including MR Targeted Case Management services). MR Targeted Case Management quarterly reviews must be completed by the last day of the month in which they are due, with a grace period of up to the last day of the month. However, the original quarterly due dates should always resume if this grace period must be utilized.

2. There must be evidence that quarterly reviews for the MR Waiver services are completed at the end of each quarter and as determined by the effective start date of the CSP. However, the original quarterly due dates should always resume if this grace period must be utilized.

3. The quarterly review for each service, including case management, will be reviewed to determine if it addresses a) the results of the services; b) any significant events; c) the individual's and, when appropriate, the family's satisfaction with the services and other input; and d) changes in the goals or strategies when they are ineffective or upon the individual's request.

C. A comprehensive review of each service occurs annually.

1. The record will be reviewed to determine if the annual review includes a combination of record review, observation of service delivery, and interviews with the individual and family to determine if the services provided are effective and match the individual's needs and desires for support.

2. Every service must have a new ISP developed at the time of the annual CSP review (no longer than 365 days (366 days in a leap year). There is no grace period. There should be documentation of individual and family involvement in the review and development of the new ISP.

The Provider is Qualified

A. There is documentation of the needed license, certification, vendor agreement, or approval.

1. It is the responsibility of the service provider to maintain documentation, readily available for review, which verifies the provider's qualifications.

2. Provider qualifications and expectations are outlined in Chapter II of this manual.

B. Certain additional requirements are met:

1. CSBs/BHAs should retain for review a copy of the Executive Director's letter to the Commissioner of DMHMRSAS certifying the qualifications of persons who will provide Targeted Case Management services, as well as the letter issued by the Commissioner of DMHMRSAS to the CSB/BHA confirming this fact.

2. Any provider of Residential Support or Personal Assistance Services must maintain documentation of the supervisor's or trainer's receipt of training and direct support staff's successful completion of the "MR Staff Orientation Workbook" and associated test. Complete and retain both the "Supervisor Assurance Certificate" and "Direct Support Staff Assurance Certificate." This documentation must include the name of the staff person, date of hire, date of successful completion of the test, completed test, and test results. Staff must have passed this test within 30 days of beginning to provide MR Waiver Services.

3. DMAS-enrolled Personal Care/Respite agencies providing agency-directed Personal Assistance or Respite services must employ or subcontract with and directly supervise a licensed RN or LPN who will provide ongoing supervision of all personal or respite assistants.

4. Providers of Day Support and Prevocational services must document that their direct care staff have been trained, within 30 days of beginning to provide MR Waiver services, in the characteristics of mental retardation and appropriate interventions, training strategies and support methods for persons with mental retardation and functional limitations.

5. A case manager may not be a direct service provider for the same individual nor the immediate supervisor of a staff person who provides MR Waiver services to the individual.

6. Crisis Stabilization services must document that they employ or utilize mental retardation professionals, licensed mental health professionals, or other personnel competent to provide clinical or behavioral services and related activities to individuals with mental retardation who are experiencing serious psychiatric or behavioral problems. The face-to-face assessments and reassessments must be conducted by a qualified mental retardation professional, as defined in Chapter II.

7. The CD Services Facilitator must be a licensed RN or have RN consulting services available. The CD Services Facilitator may not also be the case manager or direct service provider for a given individual or be the individual or the primary caregiver of the individual receiving services.

8. Agencies providing Companion services must have a companion supervisor who possesses a bachelor's degree in a human services field and at least one year of experience working in the mental retardation field, or is an LPN or an RN with a current license to practice in the Commonwealth.

9. Staff providing Residential Support, agency or Consumer-Directed Personal Assistance, agency or Consumer-Directed Respite, agency or Consumer-Directed Companion, or Skilled Nursing cannot be spouses, parents of minor children, or legally responsible relatives for the individuals. In addition, staff providing these services may not be other family members unless there is objective written documentation as to why there are no other providers available to provide the care. Relatives who provide services must meet the same standards as providers who are unrelated to the individual.

<u>The Services Delivered Are Consistent With Billing Limitations</u>

A. Services are authorized or preauthorized as appropriate.

1. All MR Waiver providers must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill.

2. MR Waiver services require authorization by DMHMRSAS prior to initiation in order for the provider to be eligible for

reimbursement. CD Services Facilitation does not require authorization prior to service initiation.

3. Terminations of single Waiver services are indicated on ISARs submitted to DMHMRSAS. Terminations of all Waiver services should be reflected on a completed DMAS-122.

B. There is documentation that services were provided as billed.

1. Billing for Targeted MR Case Management services must be supported by a minimum of one direct or by individual-related contact, activity, or communication and must be documented each month relevant to the CSP during any month for which a claim for Targeted MR Case Management is submitted. Written work is excluded. Billing for 90-day Targeted MR Case Management may only occur for a maximum of three months.

2. Billing for Day Support, Prevocational and Supported Employment-Group Model services must be supported by attendance documentation that verifies individual participation in the service in accordance with the ISP. The billing should indicate a total number of hours that is equal to or greater than the number of hours/units billed each day in a month. The documentation must include, at a minimum, the date services were rendered, the number of hours/units provided with specific time frames and type of service, an attendance log (or similar document), and a transportation log (or similar document) to verify that billing for non-program related transportation does not exceed 25% of total time billed that day.

3 Billing for Waiver Supported Employment-Individual Placement services must be supported by documentation of actual interventions or collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation. A log or similar document which shows the date, hours, and type of service rendered, in accordance with the ISP must be maintained.

4. Billing for Residential Support services:

a) Supported Living/In-Home services are billed for actual service hours. Documentation must include dates, times, and services that were provided in accordance with the ISP. When unavoidable circumstances occur so that a provider is at a individual's home at the designated time, but cannot provide services for the entire period scheduled, billing is

allowed for the entire number of hours scheduled that day, as long as some portion of the ISP is implemented. It is expected that this will occur rarely, and there will be detailed documentation of the date, original schedule, time services were actually provided, and specific circumstances which prevented provision of all of the scheduled services. If this occurs on a regular basis over a 60-day period, the case manager should determine the reasons, and a new ISP with fewer hours or a change in schedule must be developed.

b) Congregate Residential Support services are typically reimbursed based on an average daily amount of hours, which is established for each individual by multiplying the total hours scheduled per week by 4.3 and dividing the result by 30. When using the average daily amount of hours, there must be verification that some portion of the approved ISP scheduled service was provided that day. Documentation of activities may be maintained by the provider in a daily format and should demonstrate that the individual is regularly receiving services as scheduled. If the hours actually provided are consistently less than the ADA over a 60-day period, a revised ISAR should be submitted. No more than 30 days per month (28 days in February (29 days in leap year)) may be billed when using the average daily amount of hours. If the provider of Residential Support chooses to be reimbursed on an hourly basis, documentation must include the dates and times of actual service delivery in accordance with the ISP.

5. Billing for Therapeutic Consultation, Crisis Stabilization, Skilled Nursing, and agency-directed Respite, Personal Assistance or Companion services must be supported by documentation of the dates and times of actual service delivery. The format used for documentation of service hours should be reviewed by DMHMRSAS staff prior to use to ensure that all required components are present. Billing for Consumer-Directed services is supported by employee time sheets that are signed by the individual and employee.

6. Billing for Environmental Modifications and Assistive Technology must be supported by bills from contractors, rehabilitation engineers (if required), and equipment purchase receipts.

   Billing for Personal Emergency Response Systems must be supported by documentation regarding the installation of and

training required to use the required devise(s). Monthly billing for the ongoing monitoring services must be supported by documentation of at least monthly testing of the PERS device as well as documentation of each emergency signal which results in action being taken of behalf of the individual.

7. It is not permissible to automatically bill each month at the maximum amount authorized. For all services, if the amount billed for a given service in the month audited does not correspond to documented hours/units of services delivered, the entire quarter is audited. If that quarter's billing does not correspond to service delivery records, subsequent quarters may be audited.

8. All billing errors identified by DMAS staff are reported to the provider or the CSB/BHA for correction and to DMAS for follow-up. Billing errors identified during a formal Utilization Review are included in the report to the CSB/BHA and provider.

9. All billing must be supported by the required documentation as outlined throughout this manual. As a result of reviews conducted by DMAS, infractions will be cited in the written report of findings and may entail a request for billing overpayments or a void to continued billing. A Plan of Correction may be requested when review issues cited are pervasive, repetitive, or of a serious nature. The following is a comprehensive list of circumstances most likely resulting in billing overpayments or voids when identified during utilization or more informal service reviews:

    a) Absence of current ISP;

    b) Services not delivered as described in the ISP;

    c) Services rendered to an ineligible individual: if psychological assessment (or developmental assessment for children under age 6) and/or LOF do not reflect eligibility for MR Waiver;

    d) Case Management face-to-face contacts that are not completed in a timely manner (every 90 days);

    e) Any periods of services billed for which there is an absence of or inadequate documentation to support that the services were rendered (amounts, type, absence of data, assessment information, etc.);

f) Any periods of service billed during which the staff were not certified, the provider had not fulfilled the terms of the Participation Agreement, and/or the required license/certification/approval had been revoked;

g) Any identified billing errors, such as inaccuracies in service amounts, incorrect or absent deductions of patient-pay amount, incorrect dates of service, duplication of services, etc.;

h) There is no documentation reflecting the need for a service or for that level of service, (e.g., High Intensity Day Support, specialized supervision); and

i) Absence of a current LOF or a LOF that does not meet the requirements for eligibility.

C. If the individual has a patient-pay amount, a provider is designated to collect the following:

A copy of the DMAS-122 (Patient Information) form, completed and returned from DSS, should be in the individual's record at each provider. The provider designated as the collector of patient pay must be documented on the DMAS-122 prior to distribution to providers. Each provider agency (regardless of any patient pay responsibility) must receive from the case manager and keep on file a current copy of the DMAS-122

The DMAS-122 is updated by the local DSS, annually, and by the case manager if the individual experiences any of the following changes: a new address, a different case management agency, in income, interruption in MR Waiver services for more than 30 days, discharge from all MR Waiver services, or death. The case manager must forward the DMAS-122 to notify DSS when such changes occur. The case manager should document communications with DSS regarding the need for and receipt of the DMAS-122.

D. If a patient-pay is required, the billing indicates the correct amount.

If there is a patient-pay amount, the HCFA-1500 (12-90), the billing invoice required by DMAS, must indicate that the amount billed was decreased by the designated amount.

E. Designated MR Waiver services are not used when available from the primary source.

1. Prevocational and Supported Employment services providers, or the individual's case manager, must document, before the onset of service delivery, that these services are not available through the Department of Rehabilitative Services (DRS) or Special Education funding for individuals under 22 years.

2. There should be documentation that it was determined that the equipment or supplies provided to an individual under Assistive Technology services are not available under the *State Plan for Medical Assistance (State Plan)*. This may be documented in the individual's case management record by noting the results of reviewing the "Durable Medical Equipment and Supplies" list available from DMAS for a given item or the results of a phone inquiry to the DMAS Helpline about the item's availability through the *State Plan*, or both. There must be documentation for any equipment, supplies, and technology not purchased from a DME provider showing that it was not available from a DME provider.

**RECONSIDERATIONS AND APPEALS**

Payment to providers may be denied when the provider has failed to comply with established federal and state regulations or policy guidelines.

The provider has the right to request reconsideration of denials. The request for reconsideration and all supporting documentation, must be submitted within 30 days of receipt of the Utilization Review (UR) report to:

Supervisor, Behavioral Health and Developmental Disabilities Unit
Long-Term Care and Quality Assurance Division
Department of Medical Assistance Services
600 East Broad Street, Suite 13006
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the provider with a written response to the request for reconsideration. If the denial is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal fact-finding conference within 30 days of receipt of the written notification of the reconsideration decision. The provider must submit a detailed statement of the factual and legal basis for each item under appeal. The notice of appeal and supporting documentation shall be sent

to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the denial is upheld, the provider has the right to appeal the informal fact-finding decision by requesting a formal evidentiary appeal within 30 days of written notification of the informal fact-finding decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219